

4586

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 55, to May 1955, that I last saw the deceased alive on May 1955, and that death occurred at 6:05 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 26 1955

RECEIVED

04577

MARYLAND STATE DEPARTMENT OF HEALTH

4587

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 105

1. PLACE OF DEATH- COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Chas	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WALDORF		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) BROCK (Middle) (Last) BUTLER	4. DATE OF DEATH (Month) MAY (Day) 25 (Year) 1955		
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced	8. DATE OF BIRTH 1913
9. AGE last birthday 42 yrs.		10. DATE last birthday 42 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY odd job	
11. BIRTHPLACE (State or foreign country) Charles Co.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Georgra Lankers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Lennie Green Washington, D.C.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 5-25-55	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE C. S. Edelen (Degree or title) M.D.		ADDRESS Lat Place Rd DATE SIGNED 5-26-55	
23. SIGNATURE OF REGISTRAR Burch DATE THEREOF 5/26/55		NAME OF CEMETERY OR CREMATORY Waldorf LOCATION (City, town, or county) (State) Waldorf, Md.	
DATE REC'D BY LOCAL REG. 5-28-55		24. FUNERAL DIRECTOR Hunt & Ryon Waldorf, Md. ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 5

JUN 1 1955

RECEIVED

4588

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rack Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rack Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOCKLIN L. BUTLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 29 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4-18-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year) (Months) (Days) (Hours) (Min.) <u>11</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Daniel Butler</u>		14. MOTHER'S MAIDEN NAME <u> Evelyn Edelen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Evelyn Butler, Rack Point, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
491X Immediate cause (a) <u>Chronic Pneumonia</u>		5-27-55
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Evelyn Butler</u>		DATE SIGNED <u>5-29-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/30/55</u>	<u>Holy Ghost</u>	<u>Drane Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5/30/55</u>	<u>Julia D. Baren</u>	<u>Frederick J. J. J. J.</u>	<u>Honolulu, Hawaii</u>

2045265393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 1 1955

RECEIVED

4589

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH: <i>Charles</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Physicians near Hunt</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	STATE <i>Maryland</i> COUNTY <i>Charles Co.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physicians near Hunt</i>		STREET ADDRESS (If rural, give location) <i>La Plata</i>	
3. NAME OF DECEASED: (First) <i>HOWARD</i> (Middle) <i>E</i> (Last) <i>CRISMOND</i>		4. DATE OF DEATH: <i>May 7 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>April 8 1921</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Operator Blue Dozer</i>		11. BIRTHPLACE (State or foreign country): <i>Stafford Co Va</i>	
13. FATHER'S NAME: <i>John R Crismond</i>		14. MOTHER'S MAIDEN NAME: <i>Elise L Post</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or (unk.)) <i>No</i>		16. SOCIAL SECURITY No.: <i>226-14-0214</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or (unk.)) <i>No</i>		17. INFORMANT & ADDRESS: <i>John R Crismond, Sr. 438 Rachtus ave</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	
Immediate cause (a) <i>600.0</i> <i>Uremia + Anuria Crombridge</i>		DUE TO	
Antecedent cause(s) (b) <i>chronic pyelonephritis</i>		DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days over 10 years</i>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION:	
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, office bldg., etc.) <i>La Plata</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <i>9-25, 1955</i> , to <i>5-6, 1955</i> , that I last saw the deceased alive on <i>5-6, 1955</i> and that death occurred at <i>2:55 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Frederick M. Johnson M.D.</i>		DATE SIGNED <i>5-9-55</i>	
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>May 7 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Andrews Chapel</i>		LOCATION (City, town, or county) (State) <i>Stafford Co Va</i>	
DATE REC'D BY LOCAL REG. <i>5-10-55</i>		24. FUNERAL DIRECTOR <i>Ashebert Funeral Home Inc La Plata Md.</i>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 11 1955

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4590

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY CHARLES

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

TOWN LA PLATALIFE

HOSPITAL OR INSTITUTION OR STREET ADDRESS

PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY CHARLESCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LA PLATA WALDORFSTREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

BARBARAJEANDAUGHERTY

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

FEMALEW-U.S.SINGLEMAY 4, 1955MAY 73 1/23 1/23 1/2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

ROY FRANKLIN DAUGHERTY

14. MOTHER'S MAIDEN NAME:

ELIZABETH ANN GARDINER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NONONEROY F. DAUGHERTY
WALDORF, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

7543
Immediate cause(a) CONGENITAL CARDIAC DEFECT - PATENT

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO FORAMEN OVALE - HYPERTROPHY OF RIGHT ATRICLE AND RIGHT VENTRICLE

DUE TO

(c) ATELECTASIS, RIGHT LUNG

INTERVAL BETWEEN ONSET AND DEATH

3 1/2 Days3 1/2 Days

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death. PASSIVE CONGESTION - LUNGS, LIVER, SPLEEN

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/4, 1955, to 5/7, 1955, that I last saw the deceased alive on 5/7, 1955, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/8/55Julia H. CareyHunt & RyanWaldorf, Md

2055273415

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 10 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4591

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04581

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Wayside</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Wayside</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Joseph</i>	(Middle) <i>H</i>	(Last) <i>Dorsey</i>	(Month) <i>5</i> (Day) <i>16</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>E</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>M</i>	8. DATE OF BIRTH: <i>6-29-25</i>
9. AGE last birthday: <i>29</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Sammy Dorsey</i>		14. MOTHER'S MAIDEN NAME: <i>Rebecca Thomas</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.): <i>Yes</i>		16. SOCIAL SECURITY No.: <i>241-267681</i>	
17. INFORMANT & ADDRESS: <i>1946</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause DUE TO <i>434.1</i>		<i>5-16-55</i>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO			
(c) <i>002x</i>			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <i>Pulmonary tuberculosis (Frank C. ...)</i>			
19a. DATE OF OPERATION: <i>2</i>		19b. MAJOR FINDINGS OF OPERATION:	
21. ACCIDENT (Specify) <i>1</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 12, 1955</i> to <i>May 16, 1955</i> that I last saw the deceased alive on <i>May 16, 1955</i> , and that death occurred at <i>241-267681</i> , from the causes and on the date stated above.			
SIGNATURE <i>J. K. Delaney</i>		DATE SIGNED <i>5-16-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>5-18-55</i>	
NAME OF CEMETERY OR CREMATORY: <i>Holy Ghost</i>		LOCATION (City, town, or county) (State): <i>La Plata, Md</i>	
DATE REC'D BY LOCAL REG. <i>5/18/55</i>		REGISTRAR'S SIGNATURE: <i>Julia H. ...</i>	
24. FUNERAL DIRECTOR: <i>Archie Funeral Home La Plata, Md</i>		ADDRESS:	

BUREAU V. S.

MAY 20 1975

RECEIVED

4592

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Chas</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Chas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physician Mem Hosp</u>				STREET ADDRESS (If rural, give location) <u>116 Circle Ave</u>			
3. NAME OF DECEASED: (First) <u>Wm</u> (Middle) <u>P</u> (Last) <u>HENDERSON</u>				4. DATE OF DEATH: (Month) <u>5</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-5-90</u>	9. AGE last birthday: <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Indian Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Gov.</u>		11. BIRTHPLACE (State or foreign country): <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>John Henderson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Curtis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>none</u>			
17. INFORMANT & ADDRESS: <u>Maizie H Taylor Indian Head Maryland</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
581.0 Immediate cause (a).....				<u>Cerebral Hemorrhage</u>			
Antecedent cause(s) (b).....				<u>Dilatosis of Liver</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....				<u>1954</u>			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-20</u> , 19 <u>55</u> , to <u>5-22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-22</u> , 19 <u>55</u> , and that death occurred at <u>8:30 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. Edelen</u> (DEGREE OR TITLE) <u>Reg.</u>				ADDRESS <u>Indian Head</u> DATE SIGNED <u>5-22-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF <u>5-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Alexandria Va</u>	
DATE REC'D BY LOCAL REG. <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Paay</u>		24. FUNERAL DIRECTOR <u>Don't & Son</u>		ADDRESS <u>Waldorf, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 25 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04583

4593

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED (First) <i>Randolph</i> (Middle) <i>Preston</i> (Last) <i>Johnson</i>		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>24</i> (Year) <i>1955</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, INMARRIED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Mar. 8, 1955</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>22</i> yrs. If under 1 year <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min.</i>
11. BIRTHPLACE (State or foreign country) <i>Wash. D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Ralph Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Victorine Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>Victorine Johnson, La Plata, Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) <i>Broncho Pneumonia</i>			<i>5-21-55</i>
Antecedent cause(s) (b) <i>Diarrhea</i>			<i>5-23-55</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>6</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <i>Edelen</i> ADDRESS <i>La Plata Md</i> DATE SIGNED <i>5-24-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5-25-55</i> NAME OF CEMETERY OR CREMATORY <i>St. Marys</i> LOCATION (City, town, or county) (State) <i>Bryantown, Md.</i>	
DATE REC'D BY LOCAL REG. <i>5/24/55</i> REGISTRAR'S SIGNATURE <i>Julia H. Casey</i>		24. FUNERAL DIRECTOR <i>Ralph Johnson, La Plata, Md.</i> ADDRESS	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 26 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4594		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04584	
Item 7, Film G182, 5/27/55 fcy		CERTIFICATE OF DEATH	
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	LENGTH OF STAY (in this place) <i>3 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physician Men Hosp</i>		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED: (First) <i>Louisa</i> (Middle) <i>KNOC</i> (Last) <i>H.</i>	4. DATE OF DEATH: (Month) <i>MAY</i> (Day) <i>10</i> (Year) <i>19 55</i>		
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>10-5-1888</i>
9. AGE last birthday: <i>66</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Forming</i>	
11. BIRTHPLACE (State or foreign country): <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
13. FATHER'S NAME: <i>Unk</i>		14. MOTHER'S MAIDEN NAME: <i>Unk</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>Unk</i>		16. SOCIAL SECURITY No.: <i>None</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Vining La Plata, Md</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
155X Immediate cause (a) <i>Acute congestive heart failure</i>			<i>1 hrs.</i>
Antecedent cause(s) (b) <i>Hepato-renal failure</i>			<i>1 day</i>
(c) <i>Adeno-Carcinoma of Gall Bladder with metastasis</i>			<i>6 months</i>
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <i>10 May 55</i> 19b. MAJOR FINDINGS OF OPERATION: <i>Adeno-Carcinoma of Gall Bladder with metastasis</i>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>No</i>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 1955</i> to <i>10 May 1955</i> , that I last saw the deceased alive on <i>10 May 1955</i> , and that death occurred at <i>6:15 P</i> m., from the causes and on the date stated above.			
SIGNATURE <i>John M. Johnson M.D.</i>		DATE SIGNED <i>10 May 55</i>	
23. BURIAL, CREMATION REMOVAL (Specify): <i>Cremation</i>		DATE THEREOF <i>May 11 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		LOCATION (City, town, or county) (State) <i>Northland Maryland</i>	
DATE REC'D BY LOCAL REG. <i>5/20/55</i>		24. FUNERAL DIRECTOR <i>Woods & Ryan</i> ADDRESS <i>Waldorf Md</i>	

RECEIVED

MAY 23 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4595

CERTIFICATE OF DEATH

Reg. Dist. No. 04585

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Id</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Rison</i>		LENGTH OF STAY (in this place) <i>20 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rison</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>Matilda</i> (Middle) <i>Matilda</i> (Last) <i>Manuel</i>				4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>3</i> (Year) <i>1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>Negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>		8. DATE OF BIRTH: <i>88</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>—</i>		11. BIRTHPLACE (State or foreign country): <i>Rison Id.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Not known</i>				14. MOTHER'S MAIDEN NAME: <i>Not known</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>If No</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>(Half-Brother) Joe Smallwood Rison Id.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
422.2 Immediate cause (a) <i>Chronic Myocarditis</i>						2 years	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <i>Older sister</i>							
19a. DATE OF OPERATION: <i>0</i>				19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While nt Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/28</i> 19 <i>55</i> , to <i>5/3</i> 19 <i>55</i> , that I last saw the deceased alive on <i>4/28</i> 19 <i>55</i> , and that death occurred at <i>4:30 P</i> m., from the causes and on the date stated above.							
SIGNATURE <i>Frank G. Susan Jr. S.</i>				(DEGREE OR TITLE) <i>Indian Head, Id.</i>		DATE SIGNED <i>5-3-55</i>	
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>May 7, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Alexander's Chapel</i>		LOCATION (City, town, or county) <i>Chickens</i> (State) <i>Id.</i>	
DATE REC'D BY LOCAL REG. <i>5-3-55</i>		REGISTRAR'S SIGNATURE <i>Mary Southland</i>		24. FUNERAL DIRECTOR <i>Montgomery Bros</i>		ADDRESS <i>713-Jh. ave NW</i>	

RECEIVED

MAY 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04586

4596

CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Charles</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Weymouth</i>		LENGTH OF STAY (in this place) <i>75 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Weymouth</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural, give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>Kate</i> (Middle) <i>Marbury</i> (Last) <i>Marbury</i>				4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>23</i> (Year) <i>1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>		8. DATE OF BIRTH: <i>April 1880</i>	
9. AGE last birthday: <i>75</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME: <i>George Lawson</i>				14. MOTHER'S MAIDEN NAME: <i>South (?) Lawson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>Kate Barry, Weymouth, Md (Daughter)</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <i>Coronary Occlusion</i>						<i>Immediate</i>	
DUE TO							
Antecedent cause(s) (b) <i>Hypertensive Heart Disease</i>						<i>3-4 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <i>Pneumonia & Emic</i>						<i>4-5 yrs</i>	
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 51</i> , 19 <i>55</i> , to <i>May 23</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>May 21</i> , 19 <i>55</i> , and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Frank A. Susan</i>				(DEGREE OR TITLE) <i>Ind. Med. Dir.</i>		DATE SIGNED <i>5-23-55</i>	
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>5-26-55</i>		NAME OF CEMETERY OR CREMATORY: <i>Oak Grove Baptist Church Weymouth, Md</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <i>May 25 1955</i>		REGISTRAR'S SIGNATURE <i>J. V. Thompson</i>		24. FUNERAL DIRECTOR <i>Perry & Cofer</i>		ADDRESS <i>Olden Springs Md</i>	

BUREAU V. S.

MAY 27 1955

RECEIVED

4597

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X

TOWN

Part Lohasco

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Part Lohasco

X

STREET ADDRESS

(If rural, give location)

1

3. NAME OF DECEASED:

(First)

Joseph

(Middle)

Berry

(Last)

OLIVER.

5. SEX:

M.

6. COLOR OR RACE:

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

M.

8. DATE OF BIRTH:

Oct. 1, 1888

4. DATE OF DEATH:

(Month)

May

(Day)

1st

(Year)

1955

9. AGE last birthday:

66

10. UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

Farming

11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

James Oliver

14. MOTHER'S MAIDEN NAME:

Mary C. Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

Mary E. Oliver, Part Lohasco, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause

(a)

Coronary occlusion.

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

Crown artery disease.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

30 sec.

1 year.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not white work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1940, to May, 1955, that I last saw the deceased alive on May, 1955, and that death occurred at 4:35 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/2/55

Julius W. Vasey

La Plata, Md. 2 May 55. Hilltop, Md. Wheat Funeral Home, La Plata, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 6 1955

RECEIVED

4598

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Lablata</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Waldorf</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physician Memorial Hospital</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
						<i>Practor</i>	
5. SEX: <i>7</i>		6. COLOR OR RACE: <i>W.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>S</i>		8. DATE OF BIRTH: <i>5-15-55</i>	
						9. AGE last birthday: <i>15</i> yrs. <i>15</i> months <i>11</i> days <i>11</i> hours <i>11</i> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Md.</i>	
13. FATHER'S NAME: <i>William Sidney Swann</i>				14. MOTHER'S MAIDEN NAME: <i>Frances Lorena Practor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Frances L. Practor, Waldorf Md.</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <i>Respiratory collapse</i>							<i>10 min</i>
DUE TO							
Antecedent cause(s) (b) <i>prematurity</i>							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:							20. AUTOPSY?
19b. MAJOR FINDINGS OF OPERATION:							Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <i>15 May 1955</i> , to <i>16 May 1955</i> , that I last saw the deceased alive on <i>15 May 1955</i> , and that death occurred at <i>12:30 P</i> m., from the causes and on the date stated above.							
SIGNATURE <i>J. R. Wooddy</i>				(DEGREE OR TITLE) ADDRESS <i>Md La Plata Md</i>		DATE SIGNED <i>16 May 55</i>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF <i>5/16/55</i>		NAME OF CEMETERY OR CREMATORY <i>St. Peter's</i>		LOCATION (City, town, or county) (State) <i>Waldorf Md</i>	
DATE REC'D BY LOCAL REG. <i>5/16/55</i>		REGISTRAR'S SIGNATURE <i>Julia H. Boney</i>		24. FUNERAL DIRECTOR <i>Hunt & Ryon, Waldorf Md</i>		ADDRESS	

2055183310

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4599

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04589

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last)				DATE OF DEATH: (Month) (Day) (Year)			
MARVE++A STEWART				5 18 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Widowed	9-29-74	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
H				Charles Co Md			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
George Parker				Sarah Roach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
# no				George E. Stewart			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a).....						1-11-55	
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY?	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-11-55, to 5-18-55, that I last saw the deceased alive on 5-18-55, and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
J. Edelen				Laplace Md		5-18-55	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 27 1955		St Marys		Bryantown Md	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5/20/55		Julia Hasey		Robert Funeral Home Inc		K. P. Lane	

BUREAU V. S.

MAY 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Reg. Dist. No. 04591									
tem 2, Film C183 6-29-55 et									
1. PLACE OF DEATH: CHARLES					2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY Ches		MARYLAND			STATE Md		COUNTY Ches		
CITY (If outside corporate limits, write RURAL OR and give nearest town.)		LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural, give location)		
X La Plata					Grayton		X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS									
Phy. Mew. Hospital									
3. NAME OF DECEASED: (First) (Middle) (Last)					4. DATE OF DEATH: (Month) (Day) (Year)				
Lemuel WASHINGTON					5 7 19 55				
5. SEX: m		6. COLOR OR RACE: Cul		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: 9-27-1874		9. AGE last birthday: 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
				Dnd					
13. FATHER'S NAME: UNKNOWN					14. MOTHER'S MAIDEN NAME: MAF C. WASHINGTON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)					16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:		
H NO									
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:								INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) Acute Congestive Cardiac Failure DUE TO								24 hrs.	
Antecedent cause(s) (b) Arteriosclerotic Cardiovascular Disease DUE TO								1 yr.	
(c)									
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION:					19b. MAJOR FINDINGS OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 4-7-55, to 5-8-55, that I last saw the deceased alive on 5-8-55, and that death occurred at 6:10 a.m., from the causes and on the date stated above.									
SIGNATURE					(DEGREE OR TITLE)			DATE SIGNED	
Harrison Larbo M.D.					La Plata Md			5-8-55	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial		5-10-55		Oak Grove - Riverside, Md.		Riverside		Md	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
5-10-55		Mary Southland		Penny & Cofer		Pisgah, Md			

RECEIVED
MAY 11 1955
BUREAU V. S.

04592

MARYLAND STATE DEPARTMENT OF HEALTH

46-1

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phy Memorial Hosp</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Andrew</u> (First) <u>W</u> (Middle) <u>Williams Jr</u> (Last)		4. DATE OF DEATH <u>5</u> (Month) <u>9</u> (Day) <u>1955</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>6-7-43</u>
9. AGE last birthday <u>11</u> yrs.		If under 1 year: Months <u>11</u> Days <u>9</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Charles Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Andrew Williams Sr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moreland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mary Moreland Waldorf md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
936.6 Immediate cause (a) <u>Acute respiratory failure</u>			<u>5-9-55</u>
Antecedent cause(s) (b) <u>Cerebral hemorrhage</u>			<u>5-6-55</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hit by baseball in head</u>			<u>5-6-55</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office, etc.) OF INJURY <u>Bedroom</u>	
CITY OR TOWN <u>Waldorf</u> COUNTY <u>Charles</u> STATE <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>6</u> <u>55</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Hit in head by baseball</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/>			
SIGNATURE <u>R. Hedden</u> (Degree or title)		DATE SIGNED <u>5-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>5/12/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>		LOCATION (City, town, or county) <u>Waldorf Md</u> (State)	
DATE REC'D BY LOCAL REG. <u>5/12/55</u>		24. FUNERAL DIRECTOR <u>Hunter & Ryan</u> ADDRESS <u>Waldorf md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1955

BUREAU V. S.

4692

CERTIFICATE OF DEATH

Reg. Dist. No. 100

I. PLACE OF DEATH:

COUNTY CHARLES MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) HUGHESVILLE (RURAL) LENGTH OF STAY (in this place) LIFE
 TOWN HUGHESVILLE (RURAL)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS GILBERT SWAMP ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY CHARLES
 CITY (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE (RURAL)
 OR TOWN HUGHESVILLE (RURAL)
 STREET ADDRESS (If rural, give location) GILBERT SWAMP ROAD

3. NAME OF DECEASED: (First) (Middle) (Last)
 (Type or Print) LOUIS MAGUIRE WOODLAND, JR.

4. DATE OF DEATH: (Month) (Day) (Year)
MAY 1 1955

5. SEX: MALE
 6. COLOR OR RACE: NEGRO-U.S.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
 8. DATE OF BIRTH: DECEMBER 10, 1953

9. AGE last birthday: 1 yrs.
 IF UNDER 1 YEAR: Months Days Hours Min.
 IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

LOUIS MAGUIRE WOODLAND, SR.

14. MOTHER'S MAIDEN NAME:

ALICE ELIZABETH NEALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
4 NO

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS:
LOUIS M. WOODLAND, SR.
HUGHESVILLE, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

492X
 Immediate cause

(a) PNEUMONITIS, RIGHT LOWER LOBE AND
 DUE TO LEFT LOWER LOBE

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) TOXIC MYOCARDITIS
 DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

17 days

24 HOURS

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

0

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL 12, 1955, to MAY 1, 1955, that I last saw the deceased alive on APRIL 30, 1955, and that death occurred at 6:25 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

John H. Griffin
 23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 5-2-55

NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery

LOCATION (City, town, or county) Bryantown Md

(State)

DATE REC'D BY LOCAL REG. 5/2/55

REGISTRAR'S SIGNATURE John H. Griffin

24. FUNERAL DIRECTOR

ADDRESS

Hunt & Ryan, Waldorf, Md

MARGIN RESERVED FOR BINDING

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MAY 6 1955

BUREAU V. S.